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Convention on the Elimination of All Forms of Discrimination against Women

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Committee on the Elimination of Discrimination against Women
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Implementation of article 22 of the Convention on the Elimination of All Forms of Discrimination against Women

Report provided by specialized agencies of the United Nations on the Implementation of the Convention in areas falling within the scope of their activities

Note by the Secretary-General

Addendum

World Health Organization

1. On behalf of the Committee, the Secretariat invited the World Health Organization (WHO), on 18 October 2000, to submit to the Committee a report on information provided by States to WHO on the implementation of the Convention on the Elimination of All Forms of Discrimination against Women, in areas falling within the scope of its activities, which would supplement the information contained in the reports of the States parties to the Convention that would be considered at the twenty-fourth session. Annexed to the present note is a country brief prepared by WHO.

2. Other information sought by the Committee refer to activities, programmes and policy decisions undertaken by WHO to promote the implementation of the Convention.

3. The report annexed hereto has been submitted in compliance with the Committee's request.

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Annex

Introduction

1. Article 18 of the Convention on the Elimination of All Forms of Discrimination against Women (CEDAW) requires States parties to:

> "Submit to the Secretary-General of the United Nations, for consideration by the Committee, a report on the legislative, judicial, administrative or other measures which they have adopted to give effect to the provisions of the present Convention and on progress made in this respect ..."

Concern for women's health is an issue given some prominence both directly and indirectly in the Convention with the potential negative effects of discrimination on the health of women a theme appearing in various places. Article 12 explicitly sets forth the obligation of States parties to:

> "Take all appropriate measures to eliminate discrimination against women in the field of health care in order to ensure on a basis of equality of men and women, access to health care services, including those related to family planning."

2. Other articles, however, also call for the elimination of discrimination against women in health-related fields, for example, articles 10 (education), 14 (village women) and 16 (marriage and family relations). The interest of the Committee on the Elimination of Discrimination against Women relative to women's health is further spelled out in General Recommendations on reporting which have been issued through the years. It is noteworthy that six of the current 24 General Recommendations are explicitly related to health:

(a) 12 (1989) and 19 (1992) on violence against women;

(b) 14 (1990) on female circumcision;

(c) 15 (1990) related to discrimination against women in national strategies for prevention and control of acquired immunodeficiency syndrome;

(d) 18 (1991) on disabled women;

(e) 24 (1999) the Committee's most extensive comments on women's health.

3. While all States Parties to the Convention are obliged to report to the Committee at regular intervals, the Committee is not limited to those reports in seeking information on the situation of women. Article 22 grants to the specialized agencies of the United Nations the right to "be represented at the consideration of the implementation of such provisions of the Convention as fall within the scope of their activities". Furthermore, the article states that "the Committee may invite the specialized agencies to submit reports on the implementation of the Convention in areas falling within the scope of their activities." It is in this context that the World Health Organization is pleased to submit the present report with information which may complement the reports of States parties and draw attention to some issues related to women's health which may merit the special attention of the Committee.

4. In line with the Committee's comment in General Recommendation 24 (point 8)[1] and the approach of the World Health Organization (WHO) to women's health, the following information takes a life-cycle approach thus, information and comments relate not only to adult women but to the girl child and adolescents as well. Information on each country is grouped under various headings — basic data, children, adolescents, women, older women, and conclusions — selecting, in each case, information particularly relevant to women's health. Notes information on each country conclude with some questions or comments of possible interest to the Committee.

5. It is to be regretted that data on a number of issues important to the health of women, particularly poor women, are absent from much of the standard published information about the situation of women for all the countries being considered by the Committee at this time, both at the twenty-fourth session and in the pre-session working group. For example, little systematic information is available relative to trafficking in women and children, either the risk of its taking place or the threats to health and well-being experienced by women who are victims of trafficking. Two other important issues which are under-represented are the overall incidence, impact and male-female distribution of child labour and occupation-related health problems of women in both formal and informal work settings. These are issues which could usefully be raised in connection with every country.

6. Finally, it would be extremely useful if the Committee could emphasize the importance of women's health beyond the long-standing concern with reproductive health. For example, many countries have little systematic disaggregated data available on:

(a) Communicable diseases, such as malaria and tuberculosis;

(b) Cardiovascular diseases, which are increasingly important as killers of women;

(c) Mental health problems;

(d) Lifestyle-related disability and death, including substance abuse (smoking, alcohol);

(e) Osteoarthritis, auto immune diseases and others, which are particularly important as contributors to disability and death among older women.

Burundi

General

7. Burundi has a population of 6.7 million,[2] with an annual growth rate of 1.7 per cent.[3] The life of the whole population has clearly been seriously affected in recent years by war and instability throughout the region as well as the human immunodeficiency virus/ acquired immunodeficiency syndrome (HIV/ AIDS) pandemic. As of 2000, the ratio of women to men stood at 104:100.[4] Life expectancy at birth has worsened over the last decade, declining from 52 years to 44 years for women and from 49 years to 41 for men.[5] Economically, the country is in the low-income category, with a per capita gross national product (GNP) of US$ 140.[6]

Children

8. Nearly half the population (46 per cent) is under the age of 15 years.[7] Infant mortality is still relatively high. The 1995-2000 rates have been estimated at 112 per 1,000 live births for girls and 125 for boys, the mean having increased from 110 in 1990 to 136 in 1999.[8] In 2000, UNICEF reported the under-five mortality rate at 180 per 1,000 live births, up from 176 in 1998, but showing some improvement from a high of 255 in 1960.[9]

9. Fifty-eight per cent of one-year-old children were immunized for tuberculosis in the 1995-1998 period. Other immunization data indicates 50 per cent for tuberculosis, diphtheria, pertussis and tetanus; 51 per cent for polio and 44 per cent for measles.[10] Malnutrition is a serious problem among children, with 11 per cent of under-fives estimated to be severely underweight and 43 per cent showing some stunting.[11]

10. A rapidly emerging problem is that of children (0-15) with HIV/AIDS. By the end of 1999, the reported total had reached 19,000 or 3 per cent for those under the age of five years. Furthermore, 230,000 children under the age of 15 had lost their mother or both parents to AIDS since the beginning of the epidemic (data end 1999).[12]

11. The school enrolment ratio is low but favours boys; at the primary level, it is 46 for girls against 55 for boys and, at the secondary level, 5 per cent (girls) against 9 per cent (boys).[13] This differential in educational participation imposes a significant disadvantage on girls in many aspects of life, including in health.

12. Unfortunately, disaggregated data is not available to determine if there are differentials between boys and girls in other aspects of health (for example nutrition, the numbers and situation of children infected with HIV and/or orphaned by AIDS), and how serious those differentials might be.

Adolescents

13. The population in Burundi aged 10-19 constitutes 24 per cent of the total.[14] The most important issues in this age group relate to sexual and reproductive health, particularly infection with HIV. An estimated 12 per cent of women and 6 per cent of men aged 15-24 years are reported to be living with HIV/AIDS. The differential between girls and boys in the younger age group (15-19 years) is conspicuous as HIV infection is reported four times higher among girls than among boys.[15]

14. These figures suggest that major programming in HIV prevention in the coming years should focus on adolescents, working to create environments which promote the empowerment of girls, enabling them to protect themselves more effectively from infection. At the same time, in line with the report of the Ad Hoc Committee of the Whole of the twenty-third special session of the General Assembly, programmes are needed:

"to encourage and enable men to adopt safe and responsible sexual and reproductive behaviour, and to effectively use methods to prevent unwanted pregnancies and sexually transmitted infections, including HIV/AIDS".[16]

Women

15. The ratio of women to men in Burundi is 104:100, and most health concerns relate to the reproductive function. Notably, the prevalence of contraceptive use is only 9 per cent,[17] with a total fertility rate of 6.2 per woman.[18] Only 24 per cent of deliveries are attended by trained health personnel,[19] which partly explains the high maternal mortality rate in 1998 of 800 per 100,000 live births, although this is a decrease from 1,300 in 1990.[20]

16. Adults (15-49) with HIV/AIDS are estimated at 340,000, or 11.3 per cent of the total population in that age group. Fifty-six per cent or 190,000 are women.[21] Seroprevalence among antenatal women in the major urban area (Bujumbura) was 19 per cent in 1998, but in the age group 25-29 the figure was 30 per cent. Among sex workers, the figure rose to 42 per cent. Clearly, HIV/AIDS is the main threat to the health of women.

17. Illiteracy is 51.6 per cent for women aged 15-24 compared with 40.2 per cent for men in the same group.[22]

Older/ageing women

18. The population of Burundi over 60 years of age is comparatively small — only 5 per cent of the female population and 3 per cent of the male.[23] The ratio of women to men in this age group is 155:100, while among those over 80 it is 200:100. Life expectancy at age 60 is 14 for women and 13 for men.[24]

Conclusion

19. Burundi faces many challenges to improve the health of women. Most urgent among them are the high maternal and infant mortality rates, the low level of educational attainment, and, above all, the emergence of HIV/AIDS.

Comment

20. The general situation of Burundi — a country of extremely low income, seriously impacted by HIV/AIDS, an extended period of war and instability, very high fertility rates and high mortality rates — has important implications for the mental and physical health of the whole population but particularly for women and growing children, especially girl children. For example, the high ratio of women to men in the population may suggest that there is a high level of involvement of women in the economy and that they bear a heavy burden in that they must provide financial support for their families in addition to fulfilling their care-giving and household management roles. Access to basic health information and services are limited. At the same time, the general absence of data disaggregated by sex (except as related to HIV/AIDS and education) makes it difficult to evaluate the degree to which discrimination against girls and women or the special circumstances of gender roles may make their specific situation even worse than available data suggest.

21. In view of this, the Committee may wish to ask questions about the Government's overall data collection, analysis and planning system, including in the field of health. Special attention may be recommended to the situation of particularly vulnerable women and girls and those of marginal groups. Availability of disaggregated data and regular gender analysis in the field of health could assist in priority setting and contribute significantly to improving availability of non-discriminatory programmes in health and to sex-specific and gender-sensitive health service development.

22. Data on children dying of preventable childhood diseases is another indicator suggesting weakness in the coverage and outreach of the health system. Disaggregated data is not available on immunizations but the Committee may wish to ask about government plans to improve immunization coverage for all children, with particular attention given to appropriate action to assure equal access to immunization by girls and boys.

23. HIV/AIDS is clearly a priority health concern for all women and girls, both those at risk as well as those already directly infected and affected. This is a field where discrimination is central to women's vulnerability to infection and to the burdens borne by

women living with AIDS and caring for themselves and family members living with AIDS. Access to information, services, protection against discrimination and economic and social support are crucial to women's situation as well. Effective action against HIV/AIDS requires expanded and well-targeted work to reduce the spread of all sexually transmitted infections.

24. The Committee may therefore consider asking questions related to availability and gender sensitivity of information and service to combat sexually transmitted infections including HIV, as well as a range of issues related to information, care, treatment and services for people living with AIDS, in particular women and girls. Appropriate treatment for HIV-positive women to reduce the likelihood of mother-to-child transmission and extend the healthy life of the HIV-positive mother is of importance to all society but particularly the mother and child concerned.

25. With reference to HIV/AIDS, the Committee may also wish to raise some questions about the situation of women of all ages who have been widowed and of elderly women. In both cases, women are often the sole economic support for the family in addition to continuing with their traditional care-giving and household management roles. The combination is a threat to their mental and physical health, particularly if they themselves are HIV-positive. As the number of women grows, serious attention will need to be paid to the development of special programmes to complement economic, social and health programmes and to safeguard the human rights of the women affected.

26. Finally, given the country's history of social instability and armed conflict, the Committee may wish to raise some questions related to the important and distinctive mental and physical health needs of refugee, internally displaced and migrant women and their children.

Kazakhstan

Overview

27. Kazakhstan has a total population of 16.2 million, with ratio of 105:100 women to men.[25] The average population growth rate during the period 1995-2000 was -0.4 per cent. Sixty per cent of the population live in urban areas, which are growing at a rate of 1.4 per cent per annum.[26] Between 1990 and 2000, female life expectancy at birth declined from 73.4 years to 72.0. Male life expectancy also declined during the same period although the change was smaller, going from 63.9 to 63.0 years.[27]

28. A per capita gross national product of $1,310 (1998) places the country in the middle-income category.[28] The percentage of the population living below the poverty line is not known.

Children

29. Children under the age of 15 make up 28 per cent of the population, one quarter of them under five years.[29] During the period 1995-2000, the infant mortality rate was 30 per 1,000 live births for girls and 39 for boys.[30] This gave a mean of 36 in 1998, a reduction from 55 in 1960.[31] The mortality rate for under fives (per 1,000 live births) showed a significant reduction between 1960 and 1998 from 74 to 43 with lower mortality among girls as compared with boys.[32] Immunization rates for tuberculosis, diphtheria, pertussis and tetanus (DPT), polio and measles (1995-1998) were generally good (99-100 per cent) at one year of age for both girls and boys.[33]

30. Malnutrition is a problem in children, with 2 per cent reported severely underweight and some 16 per cent showing evidence of stunting.[34] There is no information on girl-boy differentials. HIV/AIDS is less evident as a problem than in many other countries. Fewer than 100 children are reportedly affected. Fewer than 1 per cent of children have been orphaned as a result of AIDS.[35]

31. Primary education has good coverage and is equitable in Kazakhstan. At primary school, the reported enrolment ratio for girls and boys stands at 95:96.[36]

Adolescents

32. Twenty per cent of the population of Kazakhstan are aged 10-19.[37] There is a troubling suicide rate (4.8 for females and 12.7 for males[38]), indicating that some adolescents, especially boys, experience serious problems in the transition from childhood to adulthood and that the formal and informal systems designed to meet the needs of young people are wanting in this regard. Unfortunately, data on adolescents, though plentiful, has not been systematically presented. It is hoped that the recently established Commission on the Welfare of Women will give special attention to the

question of the potential, needs, risks and special vulnerabilities of adolescent girls/young women in their data collection and analysis.

Women

33. Contraceptive prevalence during the period 1990-1999 was estimated at 59 per cent.[39] The total fertility rate is 2.3 per woman, down from 4.5 in 1960.[40] Abortion continues to be practised widely and is considered the main means of contraception. In 1997, 156,800 abortions were performed.[41] Complications from abortion, including death, are high. Notwithstanding the fact that 100 per cent of deliveries are attended by trained personnel, maternal mortality is among the highest in the European region. Data reported by the country for 1998 show 55 deaths per 100,000 live births. Assessments of maternal mortality based on clinical data show a higher rate of 77 per 100,000.

34. Cardiovascular mortality among women has been increasing since 1994 and is more than twice the European Union average. The mortality rate for females from ischaemic heart disease (61.45) likewise is twice the European average (1998).

35. HIV/AIDS is beginning to emerge as a problem. The estimated number of HIV-positive adults (15-49) in 1999 was 3,500, giving an adult rate of 0.04 per cent.[42]

36. Educational opportunities are good enough that only 0.2 per cent of women and 0.3 per cent of men are illiterate at ages 15-24.[43]

Older/ageing women

37. Fourteen per cent of the female population is over 60 years of age, while only 9 per cent of the male population is in that age group.[44] The ratio of women to men is 164:100 in this age group but rises to 361:100 after the age of 80.[45] Life expectancy at age 60 is 20 years for females and 15 for males.[46] There are no data on the main health problems of the ageing population.

Conclusion

38. Kazakhstan, as a country with an economy in transition, has suffered the economic decline of the last decade, in common with some of the other countries in this region. However, the basic infrastructure upon which to base improvements in the key challenge areas, reproductive morbidity and the emergence of HIV/AIDS, is available. Data collection and analysis will be an important area to target.

Comment

39. In considering the health of women, particular note should be taken of (a) the high ratio of women to men (105:100 overall; 164:100 over 60 years of age and 361:100 after the age of 80) and (b) the very high percentage of the population living in urban areas (60 per cent). Both of these circumstances undoubtedly have a great impact on the health and well-being of the women of Kazakhstan.

40. The Committee may wish to ask about the cause of the imbalance in the numbers of women and men and any special challenges raised to the mental, physical and/or social health and well-being of women and their families. It seems likely that many women are functioning as heads of households, thus bearing the multiple burdens of family care and provision of economic support as well. Given the increasing number of older women in the population and the female-male imbalance in favour of older women, the Committee may wish to consider encouraging the Government to give special attention to such women. They are often the sole economic support for the family in addition to continuing with their traditional care-giving and household management roles. This combination can present a real threat to mental and physical health. As the number of women grows, serious attention will need to be paid to the development of special programmes to complement economic, social and health programmes and to safeguard the human rights of the women concerned.

41. With reference to the high percentage of urban dwellers, questions might be considered about the government response to common urban health problems, such as those associated with urban air pollution, violence against women, changing gender roles, occupation-related health problems and urban poverty. In all cases, sex-specific differentials in health which might arise from differences in exposure, vulnerability or access to information/treatment should be investigated.

42. The nature and quality of assistance provided to women prior to, during and after delivery might be questioned given the continuing comparatively high levels of maternal mortality. Furthermore, the

Government might be encouraged to ensure for women and men easy access to a variety of contraceptive methods and especially to increase utilization of methods which are of lower risk to women than abortion.

43. It is to be regretted that data is not easily available on women who are particularly vulnerable to exploitation or discrimination, such as women in extreme poverty, women in sex work or women belonging to marginalized groups.

Maldives

Basic indicators

44. Maldives has a total population of 286,000, of whom 139,000 are females and 147,000 males giving a female-to-male ratio of 95.[47] Life expectancy data are unusual in Maldives, life expectancy at birth is longer for males than for females. It was 66 for males during the period 1995-2000, while it was 63 during the same period for females.[48] The population is growing at 2.6 per cent per annum. The gross national product per capita was $1,160 in 1997, thus placing the country in the middle-income group.[49] There are no data on the population below the poverty line of $1 a day.

Children

45. Children below 15 years of age make up 43 per cent of the total population.[50] At age one 99 per cent of girls and 97 per cent of boys are fully immunized.[51] As of 1998, UNICEF reported a child mortality rate (deaths of children under five per 1,000 live births) of 87[52] but no data was found disaggregated by sex. During the period 1990-1998, 27 per cent of children (again without disaggregation by sex) were listed as moderately and severely malnourished.[53] No information was available on children living with HIV/AIDS. In its 1998 concluding observations, the Committee on the Rights of the Child expressed concern about the lack of awareness and information on "ill treatment and abuse of children, including sexual abuse both within and outside the family". Furthermore they expressed concern about gender disparities in secondary school enrolments.

Adolescents

46. Twenty-six per cent of the population of Maldives are aged 10-19 years.[54] Little data is easily available except a few facts related to reproductive health and adolescent marriage. The initial report of Maldives to the Committee reports the average age for first marriage of 15-16 for women (see CEDAW/C/MDV/1, para. 160). The difference in attitude towards young marriage between girls and boys is clear in United Nations data indicating that, during the period 1985-1990, 36 per cent of women 15-19 were or had been married while that was true of only 6 per cent of boys the same age.[55] In its 1998 concluding observations, the Committee on the Rights of the Child expressed concern about a range of adolescent health problems, in particular the high and increasing rate of early pregnancies, the lack of access by teenagers to reproductive-health education and services, and the insufficient preventive measures against HIV/AIDS.

Women

47. Two major problems affecting the health of women in Maldives are identified in the 1999 report of the State party: undernutrition and poor access to health services. In 1998, the Committee on the Rights of the Child also expressed concern at the high rate of divorce, considered among the highest in the world. All three of these factors have potential to have significant negative impact on the mental and/or physical health of women. Furthermore comments in the State party's report to the Committee identify social and cultural factors as well as domestic and child-care responsibilities as factors limiting women's mobility and thus causal factors reducing women's access to hospitals and quality medical care to which, in principle, they have the same access as men.

48. As is the case in middle- and low-income countries, reproductive morbidity is the greatest health concern. Contraceptive prevalence is low at 17 per cent and total fertility rate is correspondingly high at 5.3 births per woman.[56] Although 95 per cent of pregnant women received prenatal care[57] and 90 per cent were attended at delivery by trained personnel,[58] the maternal mortality ratio remained high at 350 per 100,000 live births.[59]

49. HIV/AIDS was reported to affect 0.05 per cent of adults at the end of 1999,[60] but experience elsewhere would indicate that there may be under-reporting and, given existing social-cultural patterns, including those influencing relations between men and women, there should be no cause for complacency.

50. Education levels are high, as illiteracy at age 15-24 is 1.7 for women and 1.9 for men, while at ages above 25 years it is 5.2 for both men and women.[61]

Older/ageing women

51. The percentage of the population aged 60 years in 2000 was 5 per cent for both women and men, but the female to male ratio was 88:100. Life expectancy at 60 was 17 years for women and 16 for men.[62] There is no data easily available on the health problems of special significance in this age group.

Conclusion

52. The main concerns affecting women in Maldives remain those of reproductive morbidity among adolescents and adults, and the scarcity of data in many areas, including data on causes of higher mortality and morbidity among women and girls compared with men and boys. Underlying and influencing all are the social-cultural patterns identified in the State party's report, which, in the field of health, have the effect of limiting women's access to information as well as placing them in a weak position relative to men in matters such as sexual decision-making.

Comment

53. Given the existing database on the general situation of women and social cultural patterns commented on by the State party, the Committee may wish to suggest that priority attention should be given to the development of a strong disaggregated database in the field of health, including such issues as violence against women and cardiovascular disease, careful gender analysis of special problems affecting the mental and physical health of women and alternative woman-friendly accessible methods for improving outreach and delivery of health, nutrition and reproductive health information and services, particularly to adolescent girls.

54. Attention may be directed to the specific need for data and special programmes to address the mental and physical health needs of women by age group and those who are particularly vulnerable to exploitation or discrimination, for example, women in extreme poverty, women whose mobility and access to outside information, services and health care is severely limited, women in sex work or women belonging to marginalized groups. The needs and rights of adolescent girls call for special attention because of the potential lifelong impact of unmet or incorrectly handled reproductive health complications (for example, those related to childbirth or sexually transmitted infections) and lifestyle-related issues such as smoking and drug use.

55. The nature and quality of the assistance that women are provided with prior to, during and after delivery may be questioned given the continuing high levels of maternal mortality, notwithstanding the high percentage of women receiving prenatal care (95 per cent) and assistance by trained professionals (90 per cent) when giving birth. In the context of information-gathering, consideration may be given to the role which could be played by young mothers, activists in women's organizations, religious and community leaders as sources of information as well as professional health-care providers. The Committee may also wish to consider raising specific questions related to the reported continuing pattern of young marriage. For example, are there programmes under way (in school or in the community) to encourage young women, young men and families to move towards acceptance of later marriage? Are youth-friendly, easily accessible reproductive health information and services available or being developed?

Uzbekistan

Basic indicators

56. Uzbekistan has a population of 24.3 million, of whom 12.2 million are female and 12.1 million are male.[63] There is a female-to-male ratio of 101:100. Female life expectancy at birth has declined slightly from 72.9 in 1990 to the present 71 years, the corresponding figures for males are 66.3 and 64 respectively.[64] The average population growth rate in 1995-2000 was 1.6 per cent annually.[65] Forty-one per cent of the people are urban dwellers while the urban growth rate (1995-2000) was 2.8 per cent per annum.[66]

57. The gross national product at a per capita level of $870 places the country in the middle-income group.[67] There are no data on the percentage of the population with incomes below $1 per day. Disability-adjusted life expectancy is slightly better for females than for males: 62.3 at birth and 13.4 at age 60 for females; 58.0 at birth and 11.5 at age 60 for males.[68]

Children

58. Children under the age of 15 comprise 37 per cent of the population of Uzbekistan.[69] During the period 1995-2000, the infant mortality rate per 1,000 live births stood at 39 for girls and 49 for boys, with a mean of 45 in 1998.[70] The child (under 5) mortality rate in the same year was 58,[71] but no disaggregated figures (girls and boys) were available. Immunization coverage is good, with 96 to 99 per cent of one-year-olds immunized against tuberculosis, diphtheria, pertussis and tetanus (DPT), polio and measles. Severe malnutrition affects 5 per cent of children under five.[72] The information is not disaggregated by sex; thus, it is not possible to know the comparative situation of boys and girls. HIV/AIDS affects fewer than 100 children, while less than 1 per cent of children have been orphaned as a result of AIDS.[73] Net primary school attendance stood at 83 per cent for girls and boys during the period 1990-1998.[74]

Adolescents

59. Persons aged 10-19 constitute 23 per cent of the population.[75] Little age-specific data is available on health. In 1997, the number of births per thousand females 15-19 in Uzbekistan stood at 35,[76] well below the regional average of 59. HIV/AIDS is not reported as a serious problem, affecting less than 0.01 per cent for both females and males aged 15-24 years.[77]

Women

60. Reported health problems of women are mainly related to reproductive functions. The total fertility rate has declined from 6.3 per woman in 1960 to 3.4 in 1998,[78] consistent with a relatively high contraceptive prevalence rate of 56 per cent.[79] However, abortions continue to be performed to control fertility, although the practice is declining rapidly. The maternal mortality ratio, at 19-21 per 100,000 live births,[80] could be reduced further. The illiteracy rate of 0.3 per cent of both females and males aged 15-24[81] seems to indicate an accessible and well-utilized public education system.

Older/ageing women

61. Women aged 60 years and over constitute 8 per cent of the total population, compared with 6 per cent for men.[82] Life expectancy at 60 is 20 for women and 17 for men.[83] There are no data on the main health problems affecting this group.

Conclusion

62. Uzbekistan has performed well in protecting the health and education of the female population from childhood. The abortion rates continue to be high.

Comment

63. The specific health needs of adolescent and older women are not evident from published data, nor is the capacity of public service systems, in particular the health and welfare sectors, to address them known. The Committee may wish to encourage the Government to develop the capacity for collection of disaggregated data and gender analysis of women's needs, including, in particular, their mental and physical health needs, throughout the lifecycle and the capacity of the public health and other systems to respond effectively to those needs. The lengthening of women's lifespan combined with diversification in their lives and the shrinking of the percentage of a woman's lifetime spent in childbearing necessitate the reorientation of health services. In addition, attention may be directed to the specific need for data about the health needs of women who are particularly vulnerable to exploitation or discrimination, such as women in extreme poverty, women in sex work or women belonging to marginalized groups, and the availability of special programmes to address those needs.

64. In connection with the high percentage of urban dwellers, questions may be considered about the Government's response to common urban health problems, such as those associated with urban air pollution, violence against women, changing gender roles, occupation-related health problems and urban poverty. In all cases, sex-specific differentials in health which might arise from differences in exposure, vulnerability or access to information/treatment should be investigated. In the context of women's reproductive functions particular consideration must also be given to helping women deal with the potential impact of urban air pollution on pregnancy outcomes.

Notes

[1] General Recommendation 24, (8) states, inter alia, that "States parties are encouraged to address the issue of women's health throughout the woman's lifespan. For the purposes of this general recommendations, therefore, *women* includes girls and adolescents."

[2] United Nations, *The World's Women 2000: Trends and Statistics* (New York, 2000).

[3] United Nations Population Fund, *The State of World Population 2000: Lives Together, Worlds Apart: Men and Women in a Time of Change* (New York, 2000).

[4] United Nations, *The World's Women 2000: Trends and Statistics* (New York, 2000).

[5] For women: United Nations, *The World's Women 2000: Trends and Statistics* (New York, 2000); for men, country data from the World Health Organization.

[6] World Bank, *Entering the 21st century: World Development Report 1999/2000* (New York, Oxford University Press, 2000).

[7] United Nations, *The World's Women 2000: Trends and Statistics* (New York, 2000).

[8] Ibid.

[9] United Nations Children's Fund, *The State of the World's Children 2000* (New York, 2000).

[10] Ibid.

[11] Ibid.

[12] Joint United Nations Programme on HIV/AIDS and World Health Organization "Epidemiological Fact Sheet on HIV-AIDS and Sexually Transmitted Infection: 2000 Update — Burundi".

[13] United Nations Children's Fund, *The State of the World's Children 2000* (New York, 2000).

[14] United Nations, *The World's Women 2000: Trends and Statistics* (New York, 2000).

[15] United Nations Children's Fund, "A Humanitarian Appeal for Children and Women: Burundi" (Geneva, January-December 2000).

[16] *Official Records of the General Assembly, Twenty-third Special Session, Supplement No. 3* (A/S-23/10/Rev.1), para. 72 (l).

[17] United Nations Children's Fund, *The State of the World's Children 2000* (New York, 2000).

[18] Ibid.

[19] Ibid.

[20] United Nations Children's Fund, "A Humanitarian Appeal for Children and Women: Burundi" (Geneva, January-December 2000).

[21] Joint United Nations Programme on HIV/AIDS and World Health Organization "Epidemiological Fact Sheet on HIV-AIDS and Sexually Transmitted Infection: 2000 Update — Burundi".

[22] United Nations, *The World's Women 2000: Trends and Statistics* (New York, 2000).

[23] Ibid.

[24] Ibid.

[25] United Nations, *The World's Women 2000: Trends and Statistics* (New York, 2000).

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